

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10081
2617

State File No.

Registrar's No.

FILED MAR 31 1955

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		STREET ADDRESS (If rural, give location) 11 4038 St. Louis Ave.					
3. NAME OF DECEASED (Type or Print) Lutillius Putman			4. DATE OF DEATH 3 20 55				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married			
8. DATE OF BIRTH 12-26-1900		9. AGE (In years last birthday) 54		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer- St. Louis Casting & Steel Co.			
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Missouri			
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Hyne Putman		13b. MOTHER'S MAIDEN NAME Thedis Steved			
14. NAME OF HUSBAND OR WIFE Mamie Putman		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 498-03-1187			
17. INFORMANT'S SIGNATURE OR NAME Mamie Putman		ADDRESS 4038 St. Louis Ave.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: Hypertension, essential. ANTECEDENT CAUSES DUE TO (a) _____ DUE TO (b) _____ DUE TO (c) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH Undt.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
21f. HOW DID INJURY OCCUR? 3/3 11 X		22. I hereby certify that I attended the deceased from 3-10-1955 , to 3-20-1955 , that I last saw the deceased alive on 3-20-1955 , and that death occurred at 9:10p: m. , from the causes and on the date stated above.					
23a. SIGNATURE Chw. S. Williams		(Degree or title) M.D.		23b. ADDRESS 2601 N. Whittier Street			
23c. DATE SIGNED 3-21-55		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Mar 27/55			
24c. NAME OF CEMETERY OR CREMATORY Father Oakton		24d. LOCATION (City, town, or county) (State) St. Louis Mo		DATE REC'D BY LOCAL REG. MAR 23 1955			
REGISTRAR'S SIGNATURE Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. C. Green 4214 Delmar					

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *F. A. Green*

Licensed Embalmer No. *296*

P. O. Address *4214 Selma*

*Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.